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Notice of Independent Review Decision

DATE: July 3, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Epidural Steroid Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Neurological Surgeon with over 16 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
11/04/11: MRI of the Thoracic Spine without Contrast interpreted by MD
01/19/12: Consultation by MD with Neurosurgical Association
02/28/12: MRI of the Lumbar Spine without Contrast interpreted by MD
02/28/12: MRI of the Cervical Spine without Contrast interpreted by MD
03/19/12: Followup Visit by MD
03/29/12: Followup Visit by MD
04/17/12: Operative Report by MD
04/17/12: Two-Level Myelogram interpreted by MD with Hospital
04/17/12: CT of the Cervical Spine with Contrast interpreted by MD
04/17/12: CT of the Lumbar Spine with Contrast interpreted by MD
04/19/12: Followup Visit by MD
05/02/12: UR from Group
05/23/12: UR performed by DO
05/25/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who injured his back during a work-related motor vehicle accident on xx/xx/xx.

11/04/11: MRI of the Thoracic Spine without Contrast interpreted by MD. Impression: 1. Large syrinx in the thoracic spinal cord from T1 to T7. 2. Degenerative disc disease at C5-C6, which contacts the cord causing at least moderate spinal canal stenosis. 3. Apparent subacute fractures of several thoracic vertebral bodies, which do not appear unstable.

01/19/12: The claimant was evaluated by MD who noted that he was rear-ended by another vehicle on xx/xx/xx. It was noted that he had sudden onset of neck pain and bilateral radiating shoulder and arm pain, mainly on the left. He had mild thoracic spine pain. He had lumbar pain with bilateral hip and leg pain, mainly on the left. He had a feeling of some numbness and weakness in all four extremities. It was noted that he had been taking Ultracet. On examination, he walked with a slightly flexed posture at the low back and had loss of lumbar lordosis with paralumbar muscular tightness. He used a cane for ambulation. He had several beats of ankle clonus, bilateral Babinski response, and a wide-based gait. He had generalized weakness and numbness in all four extremities. He had no focal muscular atrophy or fasciculations. It was noted that he had a thoracic syringomyelia, possibly asymptomatic. He had a cervical disc problem, which may have been contributing to his myeloradiculopathy. He also had a significant amount of lumbar pain with probable radiculopathies. Dr. recommended cervical and lumbar MRI scans and a followup visit.

02/28/12: MRI of the Lumbar Spine without Contrast interpreted by MD. L4-L5: Broad-based disc bulge slightly more focal centrally. Severe central spinal stenosis at L4-L5. Severe bilateral neural foraminal stenosis at L4-L5 . Increased T2 signal at the posterior margin of the disc consistent with an annular tear. Impression: 1. Multilevel lumbar spondylitic changes as detailed above. 2. Lesions in both kidneys may represent renal cysts but would recommend followup evaluation with a dedicated renal sonogram.

02/28/12: MRI of the Cervical Spine without Contrast interpreted by MD. Spinal stenosis was noted at C2-C4, C4-C5, and C5-C6.

03/19/12: The claimant was evaluated by MD who noted that he was seeking a second opinion. He described severe and excruciating cervical and back pain. He stated that the pain was worse with walking and standing and better with sitting. He stated that he felt radiation with numbness and tingling, apparently loss of bowel and bladder control, weakness in his arms and legs, gait changes, headaches, and problem controlling his finger. He denied any previous physical therapy, epidural steroid injections, etc. Current medications included Ultracet, naproxen, and gabapentin. On physical exam, he had an antalgic gait and forward flexed posture. He used a cane for stabilization. Functional tests were not done secondary to being extremely painful for him. Lumbar range of motion was impaired in all plains. SLR was negative bilaterally. Tone was within normal limits. No muscle weakness or fasciculation. Muscle testing showed 5/5 in all muscle groups tested. DTRs were diminished but symmetrical. No Babinski, no Hoffman's. Sensation was not particularly impaired. FABERE test was negative,

negative Lhermitte's, negative Spurling's, negative Tinel's, negative Phalen's, negative Waddell sign. X-rays showed severe degeneration of the L5-S1 level with facet arthropathy at that level. ASSESSMENT: 1. Degenerative disc disease of the lumbar spine. 2. Herniated nucleus pulposus of the cervical and lumbar spine. 3. Chronic pain. 4. Morbid obesity. PLAN: I will discontinue the naproxen. I will order Celebrex 200 mg p.o. q.d. b.i.d., Flexeril 10 mg p.ro. q. h.s. I will order epidural steroid injections for C5-C6 as well as L4-L5 and L5-S1. The patient also will be referred to physical therapy for the cervical and lumbar spine program. The patient will be seen in this office in four weeks for follow-up of his pain as well as rehabilitation intervention.

03/29/12: The claimant was reevaluated by, MD who noted that he had been to for chronic pain management since previous visit two months prior. He was noted to use a cane for ambulation. He was noted to have severe lumbar pain with bilateral radiating hip and leg pain. It was noted that his lumbar MRI scan showed multilevel disc pathology,. Mainly at the L4-L5 level where he had a disc protrusion with multifactorial severe canal stenosis with severe bilateral foraminal stenosis. He stated that he was getting worse with increasingly severe pain, weakness, and numbness. He had bilateral Babinski response and several beats of ankle clonus as well as a wide-based gait. The plan was to obtain cervical and lumbar myelogram and post-myelogram CT scan for surgical planning. Dr. stated, "This man undoubtedly will need surgery, initially in the cervical area to decompress the spinal cord and nerve root to try to prevent any further myelopathy."

04/17/12: Operative Report by MD. Procedure: Myelogram. A good quality study was obtained showing central and bilateral C5-C6 defects with cord and root compression and L4-L5 spondylolisthesis with central and bilateral defects with stenosis.

04/17/12: Two-Level Myelogram interpreted by MD. Impression: Mild spinal stenosis of the cervical spine at C5-C6 and also at L4-L5 and possibly L5-S1.

04/17/12: CT of the Cervical Spine with Contrast interpreted by MD. SUMMARY: Degenerative disc disease and cervical spondylosis at C5-C6 with bilateral neural foraminal narrowing.

04/17/12: CT of the Lumbar Spine with Contrast interpreted by MD. SUMMARY: Degenerative disc disease at L4-L5 and L5-S1 with spinal stenosis and neural foraminal narrowing.

04/19/12: The claimant was seen in follow-up by MD who noted that they would proceed with anterior discectomy, interbody fusion, and plating at C5-C6. He was noted to have severe lumbar pain and bilateral radiating hip and leg pain. Work-up revealed L4-L5 spondylolisthesis with stenosis and herniated disc with central and bilateral defects at L4-L5. Dr. stated that this would need to be addressed once he was recovering from his cervical disc surgery. He continued to have

evidence of myelopathy with bilateral Babinski response, ankle clonus, and a wide-based gait with generalized weakness in all four extremities.

05/02/12: UR from Group. Request: C5-C6 anterior discectomy and fusion with plating and a 3 day stay. Explanation of findings: I have not been able to determine the medical necessity of this request based on support of the guidelines. At this point, there is no documentation that the patient has received any type of conservative treatment other than oral medications. There has been no injection and/or physical therapy. Therefore, the request for surgery is not medically necessary.

05/23/12: UR performed by DO. He complained of severe lumbar pain and bilateral radiating hip and leg pain. He has antalgic gait and forward flexed posture. He uses a cane to stabilize walking. Motion is impaired. Straight leg raising is negative bilaterally. Per note of 03/19/12, there is no weakness, 5/5 in all muscle groups. DTRs were diminished but symmetrical. Sensation is not impaired. Myelogram revealed mild stenosis at L4-L5 and possibly L5-S1. Lumbar MRI reveals broad based disc bulge at L4-L5 with ligamentous thickening and facet hypertrophic change resulting in severe bilateral neural foraminal stenosis at L4-L5 and broad based disc osteophyte complex slightly encroaching the thecal sac at L5-S1. ODG, Low Back: ESI: Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. The treating provider's last note states the patient needs cervical surgery first, and then consider the lumbar ESI. There is no indication the cervical surgery occurred. The CT myelogram showed stenosis but no overt HNP in the lumbar spine. There is no evidence of lumbar radiculopathy on exam.

05/25/12: UR performed by MD. The clinical notes submitted for review indicated the patient was being recommended for surgical intervention in the cervical spine. There is a lack of rationale for the proposed lumbar epidural steroid injection. In addition, there was no level given for the proposed injection. Furthermore, there is a lack of documentation of conservative care to include physical therapy for the lumbar spine. Official Disability Guidelines state that patients should have documented radiculopathy corroborated by imaging evidence and failure of conservative care prior to epidural steroid injections. Given the above, the request is not medically necessary at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. The claimant has not had a course of physical therapy documented as requested by Dr. on 03/19/12. The claimant has no objective radicular findings documented on exam despite his subjective complaints. He needs EMG/NCVs of the lower extremities if his radicular complaints persist despite physical therapy. The Official Disability Guidelines state objective radicular findings need to be documented before treatment with lumbar

epidural steroid injections for Lumbar sprain. Therefore, the request for Lumbar Epidural Steroid Injection is not medically necessary and non-certified.

ODG:

Epidural steroid injections (ESIs), therapeutic	**Criteria for the use of Epidural steroid injections:** *Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.* (1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. (5) No more than two nerve root levels should be injected using transforaminal blocks. (6) No more than one interlaminar level should be injected at one session. (7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007) (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. (9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment. (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**